MATRIS Trip Report

Trip Record Number_____

This template includes the current minimum elements the Massachusetts Department of Public Health requires for statewide EMS data collection and submission, pursuant to 105 CMR 170.345 and 170.347, and Administrative Requirement (AR) 5-403, Statewide EMS Minimum Data Set. Additional elements not covered by regulations are also included. **Use of this template is not required;** submission of data elements in accordance with the regulations and AR is required. Ambulance services are free to alter this or any form they use to collect their trip record information, as long as the minimum data elements are collected and submitted to the Department.

SERVICE/INCIDENT/DESTINATION

Service Name:		Service License #:		National Provider ID:	
Date:	PSAP:	Unit Notified:	Enroute:	Arrive on Scene:	
Arrive at Patient D/T	Left Scene:	On Arrival:	Transfer of Patient:	In Service:	In Quarters:
*Type of Service Request:	EMD: ❑ Yes ❑ No ❑ Unknown	*Dispatch Reason:	*Primary Role of Unit:	Unit Call Sign:	
*Type of Response Delay:		*Response Mode to Scene:	*Type of Scene Delay:		
Facility:	*Incident Location Type:	Incident Address:			
# of Patients at Scene:	MCI: ❑ Yes ❑ No	Street:	City:	State:	ZIP:
Prior Aid:❑ Yes ❑ No	Type Prior Aid:	*Prior Aid Performed by:	*Outcome:		
*Incident/Patient Disposition:	*Transport Mode	Patient Arrived at Destination Date/Time			
Destination:	*Reason for Choosing:				

Destination Type: ❑ Home ❑ Hospital ❑ Medical Office/Clinic ❑ Nursing Home ❑ EMS/Air ❑ EMS/Ground ❑ Prison ❑ Other

*Type of Transport Delay: *Type of Turn Around Delay:

PATIENT INFORMATION

Patient's First name: Middle: Last:

Hispanic Ethnicity: ❑ Yes ❑ No	*Race:	Age	Age Units: ❑ Years ❑ Months ❑ Hours	Birth date: MM/DD/YYYY	Gender: ❑ M ❑ F
Home phone:	Social Security Number:	CC/DNR/MOLST: ❑ Yes ❑ No	*Primary Method of Payment:		

Address: City: State: ZIP:

Current Medications:	Medical/Surgical History:	Barriers to Patient Care:
_____	_____	❑ Developmentally Impaired
_____	_____	❑ Hearing Impaired
_____	_____	❑ Language
_____	_____	❑ None
_____	_____	❑ Physically Impaired
_____	_____	❑ Physically Restrained
_____	_____	❑ Speech Impaired
_____	_____	❑ Unattended or Unsupervised (includes minors)
_____	_____	❑ Unconscious
_____	_____	Alcohol/Drug Use Indicators:
Allergies: ❑ NKDA	_____	❑ Smell of Alcohol on Breath / about person
_____	_____	❑ Patient Admits to Alcohol Use
_____	_____	❑ Patient Admits to Drug Use
		❑ Alcohol and/or Drug Paraphernalia at Scene

Chief Complaint: Pain Scale: Possible Injury: ❑ Yes ❑ No

Duration of Chief Complaint: Time Units: ❑ Seconds ❑ Minutes ❑ Hours ❑ Days ❑ Weeks ❑ Months ❑ Years

*Chief Complaint Anatomic Location	*Chief Complaint Organ System:	Onset Day/Time
*Primary Symptom	*Other Associated Symptoms	
*Provider Primary Impression:	*Provider Secondary Impression:	

Responsiveness Level:	Eye Opening (A)	Verbal (B)	Motor (C)	Glasgow Qualifier:❑ Legitimate Values/No Interventions
❑ Alert	❑ 4 Spontaneous	❑ 5 Oriented	❑ 6 Obeys Commands ❑ 5 Localized Pain	❑ Patient Chemically Sedated
❑ Verbal	❑ 3 To Speech	❑ 4 Confused	❑ 4 Withdraws to Pain	❑ Patient Intubated and Chemically Paralyzed
❑ Painful	❑ 2 To Pain	❑ 3 Inappropriate Words	❑ 3 Flexion to Pain	
❑ Unresponsive	❑ 1 Not at All	❑ 2 Inappropriate Sounds	❑ 2 Extension to Pain	A+B+C= (D) Total GCS: _____
		❑ 1 None	❑ 1 None	

MASS Stroke Scale: ❑ Positive ❑ Negative ❑ Inconclusive ❑ Not Applicable

Skin: ❑ Pink ❑ Flushed ❑ Cyanotic ❑ Pale ❑ Hot ❑ Warm ❑ Cool ❑ Diaphoretic ❑ Dry

Pupils: Reactive ❑R ❑L Nonreactive ❑R ❑L Dilated ❑R ❑L Mid-point ❑R ❑L Constricted ❑R ❑L

Breath Sounds: Clear ❑R ❑L Diminished ❑R ❑L Crackles ❑R ❑L Wheezes ❑R ❑L Rhonchi ❑R ❑L

VITAL SIGNS

Date/Time	Pulse	Quality	BP	BP (E) score	RR	Quality	SPO2	RR (F) score
				> 89 = 4 76-89 = 3				10-29 = 4> > 29 = 3
				50-75 = 2 1-49 = 1				6-9 = 2 1-5 = 1
				None = 0				None = 0

Underlined items are not required. Values for items with an asterisk * and printed in Blue are listed on the "Data Element Values" document.

MEDICATIONS

Date/Time:	*Medication:	Dose:	Route:	Date/Time	*Medication:	Dose:	Route

PROCEDURES

*Procedure:	Attempts	Date/Time:	Successful	Complication

EKG (ATTACH WAVEFORM GRAPHIC)

AED, Capnometry, Cardiac Monitor:
❑ AUTOMATED ❑ ADVISORY ❑ MANUAL ❑ SYNCHRONIZED ❑ PACER ❑ CAPNOMETRY ❑ SIDE-STREAM ❑ ETCO
*RHYTHM:

ECG LEAD:
❑ I ❑ II ❑ III ❑ AVR ❑ AVL ❑ AVF ❑ V1 ❑ V2 ❑ V3 ❑ V4 ❑ V5 ❑ V6 ❑ Multi Function Pads

CARDIAC ARREST

Cardiac Arrest: ❑ Prior to EMS ❑ After EMS Arrival
Witnessed by: ❑ HCP ❑ Lay Person ❑ Not Witnessed

Etiology: ❑ Cardiac ❑ Trauma ❑ Drowning ❑ Respiratory ❑ Electrocution ❑ Other
ROSC: ❑ No ❑ Yes, Prior to ED Arrival Only ❑ Yes, Prior to ED Arrival and at the ED

Resuscitation Attempted: ❑ Ventilation ❑ Compressions ❑ Defibrillation ❑ N/A Signs of Death ❑ N/A DNR Orders ❑ N/A Signs of Circulation

Reason CPR Discontinued: ❑ DNR ❑ Medical Control Order ❑ Obvious Signs of Death ❑ Protocol/Policy Requirements ❑ ROSC (pulse or BP noted)

*First Monitored Rhythm: *Rhythm on Arrival at Destination: Total # Shocks:

TRAUMA

*Cause of Injury Code:

D + E + F= Revised Trauma Score:

MOI: ❑ Blunt ❑ Burn ❑ Other ❑ Penetrating

Injury Intent: ❑ Intentional (Other/Assault) ❑ Intentional (Self) ❑ Unintentional

Patient Position in Seat:
❑ Driver ❑ Left (non-driver) ❑ Middle ❑ Right ❑ Other

Seat Row Position: ❑ Front Row ❑ Back/Cargo Row

Area of the Vehicle Impacted:
❑ Center Front ❑ Center Rear ❑ Roll Over
❑ Left Front ❑ Left Rear ❑ Left Side
❑ Right Front ❑ Right Rear ❑ Right Side

Vehicular Injury Indicators:
❑ Windshield Spider/Star ❑ Steering Wheel Deformity ❑ Dash Deformity
❑ Rollover/Roof Deformity ❑ Side Post Deformity ❑ Space Intrusion >1 foot
❑ DOA in Same Vehicle ❑ Ejection ❑ Fire

Airbag Deployment:
❑ No Airbag Present ❑ No Airbag Deployed
❑ Airbag Deployed Front ❑ Airbag Deployed Side
❑ Airbag Deployed Other (e.g., knee, airbelt)

Use of Safety Equipment:
❑ Shoulder Belt ❑ Lap Belt ❑ Child Restraint
❑ Eye Protection ❑ Helmet Worn ❑ Protective Clothing ❑ Protective Non-Clothing
❑ Personal Floatation Device ❑ None ❑ Other

NARRATIVE

Medical Control Hospital: Medical Control Physician:

Crew Member Name:	Level:	Role:	ID:	Signature:
Crew Member Name:	Level:	Role:	ID:	Signature:

REFUSAL OF CARE

I acknowledge that medical care has been offered to me by this ambulance service, I understand associated risks, and I refuse care and transport.

Patient Signature:	Date:	Witness Signature:	Date:

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